Dr Sanjay Das

Quality Report

Parkview Surgery.
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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Summary of findings

Overall summary

Dr Sanjay Das (also known as Parkview Surgery) in the Lewisham Clinical Commissioning Group (CCG) area provides primary care to approximately 3900 patients.

Parkview Surgery is open between 8am and 12.30pm on Mondays to Fridays, then 2.30pm to 7pm on Mondays to Thursdays, and 2.30pm to 6.30pm on Fridays. The practice offers extended opening hours on Mondays to Thursdays between 6.30pm and 7pm, with appointments available on booked or walk-in basis. The practice does not open at weekends.

We spoke with two patients during the day of our inspection and received feedback from 23 patients, carers and family members who completed comments cards that CQC left in the waiting area before the inspection.

Patients at the practice were protected from harm. Arrangements were in place to ensure their safety by the monitoring of safety performance, learning from incidents, maintenance of the premises, effective medicines management, and anticipating and responding to risks.

Best practice was promoted by the clinical team through reference to and implementation of published clinical guidance and commitment to professional development. The practice used audits and peer review exercises to manage, monitor and improve outcomes for its patients. The practice worked with professional colleagues and local partners to deliver appropriate care, and promoted patients' health through the delivery of health surveillance and health assessment initiatives.

Staff treated people with compassion, kindness, dignity and respect. Recent survey results and patient comments we received indicated that patients felt happy with the care and treatment they received. The clinical staff sought consent appropriately. If patients required a chaperone, this was arranged by staff.

Services in the practice were organised to meet patients' needs. New patients received assessments, and the practice operated a patient referrals and recall system. Concerns and complaints were listened to and responded to.

There were clear leadership, management and governance arrangements in place. Staff received support to learn, develop and improve in their roles.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?
Patients at the practice were protected from harm. Arrangements were in place to ensure their safety by the monitoring of safety performance, learning from incidents, maintenance of the premises, effective medicines management, and anticipating and responding to risks.

Are services effective?
Best practice was promoted by the clinical team through reference to and implementation of published clinical guidance and commitment to professional development. The practice used audits and peer review exercises to manage, monitor and improve outcomes for its patients. The practice worked with professional colleagues and local partners to deliver appropriate care.

Are services caring?
Staff treated patients with compassion, kindness, dignity and respect. Recent survey results and patient comments we received indicated that patients felt happy with the care and treatment they received. The clinical staff sought consent appropriately. If patients required a chaperone, this was arranged by staff.

Are services responsive to people's needs?
Services in the practice were organised to meet patients' needs. New patients received assessments, and the practice operated a patient referrals and recall system. Concerns and complaints were listened to and responded to.

Are services well-led?
There were clear leadership, management and governance arrangements in place. Staff received support to learn, develop and improve in their roles.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The practice provided a range of services to meet the needs of older people including home visits, seasonal flu vaccinations. The practice was due to begin more formal and regular meetings with the local palliative care teams. The practice performed well against QOF standards relating to the care of older people.

People with long-term conditions
People with long term conditions were provided with care, treatment and support according to clinical guidelines.

Mothers, babies, children and young people
The practice provided sexual health and family planning services that responded to the local needs. These included sexual health promotion advice, contraceptives, and pregnancy testing.

Screening for routine female health matters was also offered. Child health services were provided.

The working-age population and those recently retired
Specific services offered in the practice that may meet the needs of working age people included extended opening hours, health checks and advice for new patients and travel vaccinations.

People in vulnerable circumstances who may have poor access to primary care
The practice was amenable to meeting the needs of people in vulnerable circumstances who may have poor access to primary care. People in vulnerable circumstances were supported to register in the Practice.

People experiencing poor mental health
The practice worked with local partners, including the local authority and local mental health teams, to meet the needs of patients with mental health needs. They provided GP services to two local care homes for people with mental health needs. The practice performance against QOF indicators for mental health service provision was above the local average.

Summary of findings

What people who use the service say

The most recent patient survey results from the practice highlighted a number of areas where patients were satisfied with the practice performance. The results concluded that patients responding found the practice to be friendly and helpful. Patients said they were reminded to have their health checks. Patients described the doctors as very good and understanding of their needs.

We received comments from patients, carers and family members as part of our inspection, which were positive, with many patients remarking that they had been cared for by the practice for many years, that they would recommend the practice to others including family and friends, and feeling that they were well cared for and felt they received safe treatment.

On the day of our inspection, we also spoke with two patients registered in the practice, who told us they were happy with the service, felt listened to and treated with care and dignity.

Areas for improvement

Action the service SHOULD take to improve

Improve staff awareness of incidents and events that must be reported to the Care Quality Commission.

Ensure that Disclosure and Barring Service checks are carried out for any non-clinical staff who may act as chaperones in the future.

Dr Sanjay Das

Detailed findings

Our inspection team

Our inspection team was led by:

an inspector and a GP specialist advisor. Our inspection team also included a second inspector and a pharmacy inspector.

Background to Dr Sanjay Das

Dr Sanjay Das (also known as Parkview Surgery) is one of the 44 GP surgeries in the NHS Lewisham Clinical Commissioning Group (CCG) area, and provides primary care to approximately 3900 patients.

Lewisham has a higher than average proportion of black and minority ethnic residents, life expectancy is 6.8 years lower for men and 4.6 years lower for women in the most deprived areas of Lewisham than in the least deprived areas. Lewisham is the 16th most deprived out of 326 local authorities. The population distribution indicates that the number of people between 20 and 39 and children under ten is significantly higher than the England average.

The Lewisham CCG health priorities for the years 2014-16 include health promotion – helping people to improve their health, maternity services and children's care, frail older people (including care for those nearing the end of their life), supporting people with long term conditions, mental health, primary care and planned care, urgent care and Improving care for adults that need both health and social care.

Parkview Surgery staff team consisted of three GPs, two working full time and one part time, the practice manager and four reception staff. At the time of our inspection, the practice had a nurse vacancy advertised and employed a locum nurse for one day a week.

In addition to the GP services, Parkview surgery provides psychological counselling services every Friday, a dietician service every two weeks, dermatology clinic and health visitor services.

Why we carried out this inspection

We inspected this GP service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Detailed findings

Before visiting, we reviewed a range of information we had asked other organisations to share about the service.

We carried out an announced visit on 08 July 2014 between 10am and 4.30pm.

During our visit we spoke with a range of staff, including the three GPs, the practice manager, two receptionists and a consultant manager.

We also spoke with patients who used the service and reviewed comments cards where patients and members of the public shared their views and experiences. We observed how people were being cared for, and reviewed documentation relating to the governance, management and operation of the practice, such as policies, procedures and staff records.

Are services safe?

Our findings

Safe track record

There were mechanisms in place to report and record safety incidents. There was accountability for incident reporting in the practice.

There were reliable systems, processes and procedures that kept patients safe, including appropriate management of medicines, premises maintenance in line with legislative requirements, and records and information management.

There were safeguards in place to prevent unauthorised changes to patient prescriptions. All changes to patient prescriptions required GP authorisation before being made.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Such events were managed in the practice through recording, investigating, learning from them and sharing those lessons with others. For example the practice was able to show us the incidents book they maintained and evidence of actions they had taken in response to them.

There were a number of incidents recorded where patients had been abusive, aggressive or threatening towards staff. The management team told us this was an issue in the practice. The management had taken steps to address this through informal training from the practice manager in deescalating situations, involvement of the police and in rare and extreme cases, such as if there was violence or aggression towards staff and / or others, exclusion of the person concerned from the practice patient list.

Reliable safety systems and processes including safeguarding

The GPs had completed level 3 training in child protection, and one of the partners was the child safety lead for the practice.

The practice had a long standing working relationship with its local partners in the management of cases concerning vulnerable children. Regular safeguarding meetings with the community health visitor were attended by the child safety lead GP, nurse and healthcare assistant. A child protection register was maintained in the practice, for children deemed to be at risk from abuse or neglect of any kind, and this information was shared and discussed with their health visitor.

There was a chaperone policy in place, which described the role of the chaperone. The practice manager informed us that the nurse had previously been the staff member to act as chaperone. The manager planned to ensure all members of the current staff team, who may act as chaperones in the future, will have read and understood the policy before taking on those responsibilities. We noted that the staff proposed to become chaperones had not had Disclosure and Barring Service checks completed for them. These checks would verify if there was anything in their background that would make them unsuitable for that role.

Monitoring safety and responding to risk

At the time of our inspection, the practice had a nurse vacancy advertised and employed a locum nurse for one day a week. The vacancy meant that the GPs' workloads were increased as a result, but the additional work was planned for and the GPs were clear about who was taking on which additional responsibilities until a new nurse is in post.

The skill mix in the practice was such that staff were able to provide cover during staff shortages. Locum doctors were arranged to cover GP absences, and suitable pre-employment checks were made to ensure they had the necessary skills and experience.

Arrangements were in place to respond and deal with foreseeable emergencies. A fire emergency plan was in place, and staff had received training in responding to emergencies. Emergency contact details for events such as utilities failures were available for quick reference. The practice also had an emergency incident policy, which included details of who to alert and what investigations would be carried out in response to such incidents. Staff knew how to escalate and report incidents where they felt threatened. A panic alarm could be activated if staff felt threatened in extreme cases.

Medicines management

There were policies in place for all aspects of medicines management, including the storage of medicines, checking of expiry dates, handling of vaccines, emergency medicines, controlled drugs, and repeat prescriptions. Staff were aware of the policies and were following them.

Are services safe?

Medicines, including emergency medicines were all stored securely in a locked clinical room. A policy was in place for controlled drugs, although no controlled drugs were kept on the premises, or in doctors' bags. Staff were aware of how to raise concerns about controlled drugs with the local controlled drugs (CD) Accountable Officer.

There was a written process for the management of vaccines, including how to ensure the appropriate temperature was maintained so that vaccines remained effective. Staff told us that vaccines were checked, and placed in the medicines fridge as soon as they were delivered. Temperature recordings were taken of the medicines fridge twice daily, which showed that medicines requiring refrigeration and vaccines were kept at the correct temperatures to remain effective. There were clear instructions on the medicines fridge for staff to follow in the event of the fridge not working or the temperature being out of range.

There was a clear audit trail for the authorisation and issue of repeat prescriptions. Patients could request repeat prescriptions in person, online, or in writing. Prescriptions required 48 hour notice to the practice to allow them to be prepared. All repeat prescription were authorised by the GPs. There were no complaints from patients recorded on waiting times for prescriptions.

Medication reviews were carried out by the GP every six months. The electronic care record system issued an alert when a review was due. If the six month review date passed, prescriptions were not issued until the patient had attended for a review. The GPs told us they authorised repeat prescriptions, and reception staff were unable to override the need for a prescription review. The practice manager told us that some patients with stable, long-term chronic conditions may not require a face to face six monthly review; however the GPs reviewed the information held on the patient's record before issuing a repeat prescription.

Cleanliness and infection control

The practice had a number of policies and procedures relating to infection prevention and control, including a clinical waste management policy and a hand washing protocol. Correct hand washing procedures were displayed near sinks in the practice.

The practice staff were aware of the infection control policy and had signed that they had read and understood it. The policy stated the key staff, clinical and non-clinical, who were responsible for the management of infection risks and provided details of what these responsibilities entailed. Members of staff in the practice had received training in infection control.

An infection prevention and control audit was completed at Parkview Surgery in June 2014 by the Infection Control Specialist from the local area team for NHS England. We saw evidence that the practice was taking action in response to the audit recommendations, such as ensuring up to date cleaning schedules were provided to cleaning staff, and that the infection control policy was up to date.

The practice staff were aware of the Clinical Waste Management policy, and appropriate systems were in place to handle clinical waste, such as the use of clinical waste bins in all treatment rooms, and regular clinical waste collections.

The practice carried out annual Legionella risk assessment of the water system. The latest assessment indicated there were no risks of legionella bacteria developing in the water system providing the necessary actions to maintain the quality of the water system were being taken.

All areas of the practice we saw were clean and free from clutter.

Staffing and recruitment

There was a recruitment policy in place that set out the arrangements for recruiting new staff into the practice. Checks included professional registrations and Disclosure and Barring Service (DBS) checks for clinical staff.

The practice employed three GPs, a practice manager and a team of receptionists. A staff member had recently completed training as a healthcare assistant but they had not begun working in this role as they were awaiting the completion of their DBS checks. The practice had a nurse vacancy which it was recruiting to fill. A locum nurse was employed for one day a week.

Dealing with Emergencies

Although there was a business contingency plan in place, it had not been revised since 2009, so was in need of an update. The GPs and practice manager were able to describe their response plans for changes and disruptions. These included use of locum doctors to cover any GP absences, and use of agency nursing staff until their nurse vacancy was filled.

Are services safe?

Emergency medicines were kept, and there was a written protocol for the use of these medicines, a copy of which was kept with the emergency medicines storage container. The Practice manager told us that emergency equipment and medicines were checked once a week, and there were records kept to show these checks took place. Although the emergency medicines policy stated that emergency oxygen was kept, the doctor told us that this was not currently available but had been ordered. The practice had an anaphylaxis policy in place, and staff we spoke with, including reception staff, were aware of the policy to follow in the event of an emergency.

Equipment

The practice management team arranged a number of audits and assessments to ensure the premises, utilities and equipment remained safe and suitable for use. These included annual health and safety audits, a legionella risk assessment of the water system, portable appliance testing (PAT) of the electrical equipment, an asbestos management survey, and Disability Discrimination Act (DDA) compliance audit for the premises. We found that actions and recommendations made at the end of these assessments and audits were followed up by the practice. The latest health and safety, and fire risk assessments deemed the premises to be at low risk.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

Patients' assessment, diagnosis and care planning were carried out according to the latest published guidelines including those issued by the National Institute for Health and Care Excellence (NICE), which were available to the Practice clinical team electronically. We saw evidence that the clinical staff kept up to date with best practice and published guidance. For example we saw that the practice had copies of current prescribing guidelines for medicines, such as prescribing in pregnancy and an annual prescribing audit was carried out. The outcome of the audit was not available at the time of our inspection, as the audit had been carried out shortly before our inspection.

The principal GP and the practice manager were aware of the current NHS immunisation programmes to improve uptake. In Lewisham, the uptake of Measles Mumps Rubella (MMR) vaccine for children was below target. The electronic care record system at the practice automatically identified patients who required immunisations and they were invited to have these at the practice.

The practice had referral arrangements in place. Patients were referred to other services as required. For example, members of the staff team were able to provide examples of where people were referred to the community mental health team and to social services for further and more specialised care and support.

The GPs were able to give us examples of ways they had sought specialist advice to ensure the best treatment was provided to patients. For example they had sought a cardiologist's input to ensure appropriate medicines were prescribed to patients with heart conditions.

Management, monitoring and improving outcomes for people

The Practice had a system in place for completing clinical audit cycles. Examples of clinical audits included Quality and Outcomes Framework (QOF) performance, minor surgeries, and a heartburn relief medication. The practice acted upon prescribing advisors' suggestions. The findings of audits were shared and discussed among clinical staff to use to inform and improve future practice.

The GPs at this practice were part of a locality group of GPs that met monthly to discuss various issues, including clinical guidelines, common clinical and healthcare issues in the local area, and results of audits.

The GPs had completed case reviewing and peer reviews of referrals for specialist services, including to Ear, Nose and Throat (ENT), Ophthalmic, Dermatology, and Musculoskeletal services. The referrals and attendances were reviewed and the process documented. The information was used to determine if there was anything that could have been managed differently, if any referrals were avoidable and if there were lessons to be learnt about handling similar cases in the future.

Effective Staffing, equipment and facilities

There were arrangements in place for the induction of new staff and locum GPs.

Locum GPs were subject to performance reviews which included feedback from patients and staff. The consultations carried out by locum GPs were also reviewed by the senior doctors in the practice.

The GPs at the practice were subject to revalidation, the system that allows their licence to be renewed after they had been assessed as being up to date and fit to practise. These were next due to be completed in 2016 for the practice's GPs.

The GPs attended various professional training and development courses. The doctors also sought expert advice where required, such as involvement of psychiatrist in ensuring that mental capacity assessments were correctly conducted.

There were a number of audits and checks carried out at the practice to ensure the safety and suitability of the premises, including health and safety checks, electrical systems checks, water quality checks and disability discrimination act (DDA) compliance. We reviewed the records of these checks from the past two years and found that the provider had taken actions where required. For example, redecoration of the premises had been carried out which included the installation of new flooring, a new fire alarm system and an electrical fuse board.

Working with other services

There were a number of information sharing arrangements in place between the practice and partner services and organisations, to aid the effective provision and

Are services effective?

(for example, treatment is effective)

continuity of care, treatment and support to patients. There was a summary care record from the practice which hospitals could access electronically to obtain crucial information about the patients promptly, such as any allergies and their current prescribed medicines. The practice also shared information with out of hours teams as required.

Multidisciplinary meetings with other services took place. The principal doctor told us the most recent meeting with the district nurse was six months ago. Meetings with the community matron took place every three months. There were current information sharing arrangements in place with the palliative care team as required. Meetings with the health visitor and midwife took place every six weeks and clinical meetings every four to six weeks, to discuss the care of particular patients.

There was a clear audit trail for the management of medicines information received from other services. There was a process for transfer of information between providers, mainly through discharge letters and hospital results and reports. Some of this information was received electronically and others in paper form. Staff informed us that correspondence was dealt with promptly and there was no backlog of paper discharge notes that required attention.

The practice provided support to four local nursing homes, and held meetings with the homes and local pharmacies to address medicines supply issues. The practice also met with the clinical commissioning group (CCG) prescribing adviser to improve prescribing. The practice manager told us that there had been some issues with the local NHS hospital as patients were not always provided with sufficient medicines on discharge, or were not informed that they could get prescriptions dispensed at the hospital pharmacy, so this had put some pressure on the surgery to issue prescriptions urgently.

For the people living in the nursing homes registered with the Practice, the doctors told us that care plans were in place for them that were prepared following consultation by a multidisciplinary team. The doctors attend nursing home multi-disciplinary meetings at the relevant home.

Health promotion and prevention of ill health

New patients were provided with a health check from a nurse, and received healthcare advice.

The practice clinical team also provided opportunistic health promotion activities to any patient that might benefit, including smoking cessation and weight loss advice. Patients were able to obtain dietician's advice about making healthy eating choices.

The principal GP told us about the support they provided to people who were carers. This included prioritising them for appointments and referring them to social services for additional support. However we found that additional work was needed by the practice to ensure that vulnerable carers were proactively identified and their needs met. The principal GP told us they had a list of carers which was kept up to date. Carers are offered bi-annual health checks and signposted for additional support services.

Patients were invited for routine checks such as cervical smear tests and antenatal care. Childhood immunisations and flu vaccinations were also offered to the recommended groups of people, according to published guidelines.

The practice audited the uptake of immunisations and was able to run a report from their patient records system listing patients requiring immunisations. Reminders were sent for patients with due immunisations by letter, text or phone call. The practice manager told us that they were among the top five local GP practices for child immunisations. They recognised that their performance had recently dropped, and they had reviewed and monitored it to ensure they continued to meet set targets. They told us the lack of a full time nurse may have contributed to their decreasing performance with child immunisations.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There were male and female GPs available in the practice and patients were able to request their preference.

We reviewed the practice results from their General Practice Assessment Questionnaire (GPAQ), a patient survey which received 120 responses in the two week period it was conducted during December 2013. The GPAQ concluded that patients found the practice to be friendly and helpful. Patients said they were reminded to have their health checks. Patients described the doctors as very good and understanding of their needs.

We also reviewed the latest information, from 2013, for the national GP patient survey. The survey completion rate was 22%, with 98 of the 442 surveys sent out being completed and returned. The areas respondents highlighted that the practice did best in relation to the care they received from the nurse, with more than 80% of respondents responding that the last nurse they saw or spoke with was good at listening to them, treated them with care and concern and was good at giving them enough time. What people said the practice could most improve on was respondents being able to see or speak with their preferred GP, the wait time after the appointment time to be seen and how helpful reception staff were.

We received comments from patients as part of our inspection, which were positive, with many patients remarking that they had been cared for by the practice for many years, that they would recommend the practice to others including family and friends, and felt that they were well cared for and felt they received safe treatment.

There was a chaperone policy in place, which described the role of the chaperone. The practice manager informed us that the nurse had previously been the staff member to act as chaperone. The manager planned to ensure all members of the current staff team, who may act as chaperones in the future, will have read and understood the policy before taking on those responsibilities.

The Practice has access to translation services, and the reception staff were able to show us the process for arranging and booking this service.

Involvement in decisions and consent

The GPs told us that they sought consent from patients in writing for certain procedures, such as minor surgeries and contraceptive implants. Appropriate documentation was in place to allow this to be carried out, including information about the procedures and counselling documentation for certain procedures.

The waiting room in the practice displayed a wide variety of information for patients, from health promotion leaflets to support services contact details and practice information such as appointments booking and information on out of hours services. There was also a range of posters and notices about different services and diseases. Some of the information available in the waiting room was also provided in different languages.

The practice offered a telephone interpreting service for patients who did not speak English as a first language.

Patients told us they felt involved in decisions about their care and treatment. People who responded via the CQC comments cards also told us they felt satisfied with the level of information and explanations given to them as part of their care and treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

New patients were offered a consultation to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors (such as smoking and blood pressure measurements). Lifestyle advice and further consultations were arranged as necessary in response to the new patient consultation findings.

In July 2013, the practice completed the installation of a disabled toilet fitted with emergency alarm, improved access through the premises entrance and an emergency exit with ramp.

The practice provided additional flu vaccine clinics and as required extended opening hours in response to patient demand.

Data from the Joint strategic needs assessment from 2012 / 13 indicated that the rate of HIV infection in Lewisham is 7.5 per 1,000 population. This equated to approximately 1,360 individuals. This is the 8th highest prevalence in the UK. There was also a high abortion rate in Lewisham; 30 per 1,000 females aged 15-44 years, compared to 26 per 1,000 in London and 18 per 1,000 nationally.

Around 10% of 15-24 year olds screened for chlamydia are positive. Around 2% of 15-24 year olds screened for chlamydia also have gonorrhoea. We found that the practice had services in place to support people to maintain good sexual health. There was a family planning and sexual health service provided which included free condoms and pregnancy tests. Contraceptive services such as coil fitting and dermal implants were also carried out at the practice.

Access to the service

Parkview Surgery was open between 8am and 12.30pm on Mondays to Fridays, then 2.30pm to 7pm on Mondays to Thursdays, and 2.30pm to 6.30pm on Fridays. The practice offered extended opening hours on Mondays to Thursdays between 6.30pm and 7pm, with appointments available on booked or walk-in basis. The practice did not open at weekends.

Patients were able to receive telephone consultations or home visits, as well as attending the practice in person. Patients were able to pre-book their appointments up to two weeks in advance, and a number of on the day appointments were also available each day. The reception staff told us that they kept the details of patients seeking appointments to contact them to replace any late cancellations. Text reminders were sent to patients about their booked appointments. People were able to book appointments online or by phone.

The principal doctor at the practice carried out weekly visits to the nursing homes and care homes registered with the practice. Home visits were also carried out to those who were house bound.

Responses from a recent report which analysed calls to the practice and the patient survey 2013 / 14 indicated that patients were satisfied with the access to their GP. There were very few complaints recorded that related to accessing the service.

The practice welcomed people of all ages and backgrounds to register as patients, and there was a notice in their reception area indicating they did not exclude anyone from registering with them. However they told us of a few instances where they had had to exclude patients from the practice, where they had experienced violence and aggressive behaviour from the patients concerned. In each case they were reviewed at staff meetings and appropriate processes followed.

There was comprehensive information displayed in the waiting area about alternative places to access care when the practice was closed. These included the local walk in centre and local pharmacy.

Meeting people's needs

Tests results and the outcomes of referrals were followed up by the doctors in the practice, and any necessary follow ups with the patients concerned were arranged.

The reception staff told us about how the electronic patient information system used in the practice alerted them to patients requiring recalls and medication reviews dates. Patients who were also due to receive cervical smear tests, or had not responded to initial invitation to have the checks done were followed up and offered alternative appointments.

The practice had a Patient Participation Group (PPG) that met annually. We reviewed notes of their most recent meeting which showed that the members made

Are services responsive to people's needs?

(for example, to feedback?)

suggestions for improvements in the practice which were listened and responded to. We also spoke with some members of the PPG, who spoke of finding the practice management accessible.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We found through our discussions with the practice reception staff that they knew the details of the complaints policy. There was a complaints log book in place, which also prompted staff to provide people with information about making complaints. We reviewed the complaints that had been received by the practice in the 12 months preceding our inspection and found that in each case, the complaints process was followed.

The practice learnt from complaints and feedback. Complaints were discussed at staff meetings, lessons learnt shared and further actions taken. For example, following some incidents involving patients, the reception staff were provided with briefing from the practice manager about dealing with patients if the situation escalated. Staff were reminded to use a quiet tone, and for privacy to take the person to one side to discuss the matter.

There was an incident policy in place which described what to do if a person became abusive or aggressive towards staff, and the practice manager told us that they were planning to arrange more formal training for staff in this subject. The practice operated a no tolerance policy to abuse or aggression towards its staff, and this information was displayed in the waiting area.

At the annual PPG meeting, the group considered issues raised by patients through surveys, and contributed to discussions and decisions about the running of the practice. The most recent PPG meeting was held in February 2014. Ideas discussed, some of which we saw were now implemented, included displaying a photo wall of the practice staff team so people could become more familiar with the practice team, updating the practice leaflet to include the full range of services available, updating the posters in the waiting area, and reintroducing Sit & Wait appointments.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Leadership and culture

Plans were in place for the junior partner to take over the leadership of the practice when the senior partner retired. The junior partner had a clear vision of the future of the practice and was aware of the strengths and challenges they faced. The junior partner was motivated, demonstrated commitment and enthusiasm about providing a quality service and continuity of care to their patients.

The partners had a vision for the practice to become a minor surgery centre, to improve nursing care for their nursing home patients, to provide continuity of care, keep up with clinical standards and develop an in-house dermatology management centre.

The practice management team told us they historically had a problem with recruiting nurses and doctors, and at the time of our inspection they were in the process of recruiting a new nurse and additional doctors.

Staff were aware of the leadership structure and who to approach for different matters in the practice.

Governance arrangements

Staff were aware of their roles and responsibilities in the practice. Some members of staff had designated lead roles in different aspects of service provision. For example, the junior partner was the child safeguarding lead.

The practice records management system supported the staff to monitor and deliver services. For example the system generated alerts and prompts for key milestones, such as when child immunisations and development checks, and medication reviews, were due.

The practice had in place policies and procedures relating to all aspects of its service provision.

Systems to monitor and improve quality and improvement

Parkview surgery was part of a neighbourhood cluster of GP practices that met regularly to exchange ideas and conduct peer reviews.

Clinical audits were carried out in the practice, lessons learnt shared with the staff team and improvements made.

The practice monitored its performance against Quality and Outcomes Framework (QOF) standards on an on-going basis, and most recently published results, for 2012 / 2013 indicated that the practice's overall QOF score was 98.2%, which was 3.1% above the CCG area average, and 1.5% above the England average.

Patient experience and involvement

Parkview Surgery used a number of methods to obtain patients views. There was a comments and suggestions box in the practice waiting area, and responses were reviewed by the practice manager periodically. There was evidence that suggestions made by people were acted upon. For example, a patient suggestion to send text reminders about appointments was implemented.

There was a patient participation group (PPG) in the practice. Records showed they had annual meetings where they met to discuss service provision and suggest improvements.

The most recent patient survey was completed in September 2013 and the findings were discussed at the most recent PPG meeting, held in February 2014.

We received comments from people using the service prior to and during our inspection. The comments were all positive, with patients telling us they felt well cared for, treated with dignity and respect, and that that the environment was well maintained.

Practice seeks and acts on feedback from users, public and staff

Monthly staff meetings were held in the practice and minutes were kept. The meetings were attended by the entire staff team. Matters discussed at the staff meetings included sharing ideas, practice issues, incidents and complaints.

Clinical meetings were held every two week, and minutes of these meetings were maintained. Matters discussed included updated guidelines, individual cases, and practice management issues.

The practice management team recognised the importance of providing an environment where the staff felt valued and included. Training was offered to staff who wanted to expand into other areas of responsibilities, such as the reception staff member who had received training to become a healthcare assistant.

Annual appraisals were provided to the staff in the Practice. The practice doctors were subject to revalidation, which was due in 2016.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Management lead through learning and improvement

The management team was able to provide examples of how the practice responded to feedback and staff suggestions.

Staff were supported to attend training for their development such as infection control and basic life support training.

Identification and management of risk

The practice had systems in place to identify and manage risks associated with the use of equipment and facilities. A range of periodic assessments and reviews were conducted to ensure the premises and equipment was safe and suitable for use.

An incident reporting book was maintained in the practice and used for significant event analysis following incidents. We reviewed the summary of events that had been recorded and found that they had been investigated, and actions taken in response to them.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice provided GP services to four local nursing homes for people with older people. Weekly GP visits were made to the homes, or more frequently if required.

The GPs also provided home visits to patients in their own homes who were unable to visit the practice in person.

People aged 75 and over had a named GP in the practice, to ensure their care was more personalised.

The practice offered a seasonal flu vaccination service for older people and other people at risk of developing serious complications from flu.

The Practice provided particular care for certain conditions often associated with ageing, such as dementia, and a number of long term conditions. The practice Quality and Outcomes Framework (QOF) performance for 2012 / 2013 indicated that the practice was performing well against most these standards. For dementia, the practice performance was the same as the England average and above the CCG average, and for stroke or transient ischaemic attacks their performance was above the CCG average and below England average. For palliative care however, the practice performance was below CCG and England average, because it did not have regular (at least 3 monthly) multidisciplinary case review meetings where all patients on their palliative care register were discussed. There were current information sharing arrangements in place with the palliative care team, but these were not happening on a regular basis.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice monitored its performance against Quality and Outcomes Framework (QOF) indicators, some of which related to the management of long term conditions. The practice was achieving the maximum scores for its management of asthma, cancer, chronic kidney disease, chronic obstructive pulmonary disease, coronary heart disease, hypertension and hypothyroidism.

The practice liaised with a number of agencies involved in the care of diabetic patients, to derive coordinated and integrated care pathways. Referral pathways were maintained on the practice records system.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice was in an area that had poor indicators regarding sexual health. Lewisham had an HIV prevalence that was the 8th highest in the UK, as well as a high abortion rate, particularly among those having repeat abortions.

The practice provided sexual health and family planning services to meet the local needs. Long acting reversible contraception services such as Coil fitting and Dermal Implant were provided at the practice.

Condoms and pregnancy test kits were provided at no charge by the practice.

Cervical screening, advice on breast examination, and other checks concerning female health were carried out.

Mothers registered at the practice were able to receive antenatal and post natal care services. This was provided by a community midwife who carried out regular visits to the practice in response to the demand.

Child immunisations were also provided in the practice, and child development checks were offered at intervals that were consistent with national guidelines and policy.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The Practice offered extended opening hours, with appointments available between the hours of 6.30pm and 7pm on Mondays to Thursdays.

New patients were provided with a health check from a nurse, and receive healthcare advice.

The practice provided a travel vaccinations service, carried out minor surgeries and held a weekly psychological counselling service.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

People with learning disabilities registered in the practice receive additional care and support, through regular medication reviews and health checks.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had a named social worker in the local authority that they could contact for advice about supporting people with mental health needs.

GPs attended mental health reviews and mental capacity act meetings as necessary.

Parkview surgery was the GP practice for two local care homes for people with mental health needs.

The practice works with the local mental health team to ensure people experiencing mental health problems were able to receive the treatment and support they needed.

The practice monitored its performance in the provision of care to people with mental health needs. Its Quality and Outcome Framework (QOF) scores showed that for the mental health indicators it performed above the CCG average. The indicators showed that the practice performed well in ensuring physical health checks such as body mass index, blood pressure, blood glucose, total cholesterol and cervical screening was carried out for people with mental health needs. The practice performed above the CCG and national average in all these physical health check areas in 2012 / 13.